Ryan White Title I
Service Delivery Policies
Fiscal Year 2006-07
(Year 16)

Section V –
Letters of Exemption, Nutritional Assessment, Medical Necessity and Prior Authorization

Miami-Dade County
Office of Strategic Business Management

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RYAN WHITE TITLE I NUTRITIONAL ASSESSMENT LETTER FOR FOOD BANK SERVICES

(THIS DOCUMENT IS TO BE COMPLETED BY AN INDEPENDENT PHYSICIAN OR A REGISTERED DIETITIAN NOT ASSOCIATED WITH THE TITLE I FOOD BANK PROVIDER.)

TO BE COMPLETED BY PHYSICIAN

Date: _____

As the **primary medical caretaker** for _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

□ Weekly □ Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

□ One visit □ Two visits □ Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

Physician Signature_____ Name_____

Print MEO#_____

OR

TO BE COMPLETED BY REGISTERED DIETITIAN

Date: _____

As a **registered dietitian** who has completed an assessment of _____, who has a diagnosis of _____, it is my professional opinion that he/she requires food bank assistance.

Please specify frequency:

□ Weekly □ Monthly

Please specify maximum number of additional food bank visits (occurrences) recommended within a twelve-month period, which starts with the date of the client's first visit to the food bank (first occurrence):

□ One visit □ Two visits □ Three visits

This assistance will maintain the patient's health by providing a balanced, adequate diet, which the patient is currently not receiving.

RD Signature_____ Name_____

Print

RD License #_____

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Pursuant to Article VI, Section 6.4 (G) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on-site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

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RYAN WHITE TITLE I
LETTER OF MEDICAL NECESSITY FOR HOME DELIVERED MEALS
(PHYSICIAN CERTIFICATION)

As the primary physician for _____, CIS # _____, it is my professional opinion that he/she qualifies for home delivered meals assistance because he/she meets the conditions required for this service (as indicated below).

I hereby certify that:

1. This patient has the following diagnosis (check one):
   - ☐ AIDS
   - ☐ HIV+ symptomatic, with the following condition that makes home delivered meals necessary:
     (please specify condition and check one of the following: _____)
     _____ Temporary condition (specify time period _____)
     _____ Permanent condition

AND

2. This patient meets the following Project AIDS Care (PAC) Waiver condition for home delivered meals (check as appropriate):
   - ☐ The patient is homebound*; functionally impaired**; and no other person in the patient's household is able to prepare meals, or the person who usually prepares meals is temporarily absent or unable to manage meal preparation.
   - ☐ A therapeutic diet is authorized for this patient that can only be implemented through home delivered meals.

AND

3. This patient requires _____ home delivered meals per day, from the date of my signature, for a period of (check one):
   (# of meals)
   ☐ 1 MONTH ☐ 2 MONTHS ☐ 3 MONTHS

Definitions - * *Homebound:* *The individual is confined to his or her home for any period of time and is unable to leave the residence without assistance from another person. The homebound person must have no other means of obtaining meals.*

** *Functionally impaired:* *The patient has difficulty performing one or more activities of daily living such as bathing, dressing, walking, getting to the toilet, or eating. The functionally impaired person may not be capable of preparing meals.*

Sincerely,

_____	_____
Physician's Signature	Date
_____	_____
Physician's Name (please print)	Physician's Florida Medical License Number
_____	(_____)_____
Agency/Clinic/Practice Name	Physician's Telephone Number
_____	_____
Agency/Clinic/Practice Street Address	Agency/Clinic/Practice City, State, Zip

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RYAN WHITE TITLE I
DURABLE MEDICAL EQUIPMENT AND SUPPLIES
LETTER OF MEDICAL NECESSITY
(THIS DOCUMENT MUST BE ACCOMPANIED BY A DOCTOR'S PRESCRIPTION)

Date: _____

PART I - Physician's Certification

As the primary physician for _____, who has a diagnosis of *(HIV+ Symptomatic or AIDS)* _____, it is my opinion that he/she requires the following medical equipment and/or supplies due to a prognosis of _____:

Equipment _____ Quantity_____

_____

Supplies _____ Quantity _____

_____

The medical **equipment** indicated above is necessary in order to ensure the patient's well being for the time period of _____ .

The medical **supplies** indicated above are necessary in order to ensure the patient's well being for the time period of _____ .

_____ _____
Physician's Signature Date

_____ (_____)_____
Physician's Florida Medical License Number Physician's Telephone Number

_____
Agency Name

PART II - Case Manager's Certification

To be Completed by Title I Funded Case Managers

As the primary case manager for _____, CIS #:_____, Agency Assigned ID #:_____, I certify that he/she has been screened for eligibility under Title I and other funding sources. Title I (funding source of last resort) is the only program that can currently meet this client's needs for all of the equipment and/or supplies indicated above or for some of the items listed depending on the limitations defined by other benefit programs. As a Title I funded provider, I understand that this Letter of Medical Necessity, along with the attached physician's order for the above mentioned equipment and/or supplies, constitutes a certified referral for this service and confirms this client's medical and financial eligibility under the Title I program.

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RYAN WHITE TITLE I
DURABLE MEDICAL EQUIPMENT AND SUPPLIES
LETTER OF MEDICAL NECESSITY
(THIS DOCUMENT MUST BE ACCOMPANIED BY A DOCTOR'S PRESCRIPTION)

PART II - Case Manager's Certification (Continued)

To be Completed by Non-Title I Funded Case Managers

As the primary case manager for _____, Agency Assigned ID #:_____, I certify that he/she has been screened for eligibility under funding sources other than Title I. Title I (funding source of last resort) is the only program that can currently meet this client's needs for all of the equipment and/or supplies indicated above or for some of the items listed depending on the limitations defined by other benefit programs. As a non-Title I funded case manager, I understand that this Letter of Medical Necessity must be accompanied by documentation of the client's medical and financial eligibility in order for the client to receive this service under the Title I program. Therefore, the required proof of eligibility is hereby attached.

_____ _____
Case Manager's Signature Date

_____ (_____)_____
Agency Name Case Manager's Telephone Number

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RYAN WHITE TITLE I PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL HIV GENOTYPE RESISTANCE ASSAYS: TREATMENT INTENT STUDY

Date:_____

A MAXIMUM OF TWO (2) ANTIRETROVIRAL RESISTANCE TESTS MAY BE ORDERED IN ANY CONSECUTIVE TWELVE (12) MONTH PERIOD TO INCLUDE NO MORE THAN ONE (1) HIV PHENOTYPE IN ANY CONSECUTIVE TWELVE (12) MONTH PERIOD. IF THE PATIENT IS ELIGIBLE FOR HIV GENOTYPE TESTING UNDER ADAP, THE PATIENT IS NOT ELIGIBLE TO RECEIVE THIS SERVICE UNDER RYAN WHITE TITLE I.

As the primary medical caretaker for _____it is my considered opinion that he/she requires HIV genotypic resistance testing. The patient is not currently receiving antiretroviral medications and one of the following criteria has been met:

1. ___The patient is antiretroviral-naïve, and therapy is being initiated for acute HIV infection. It is likely that resistance testing at baseline will optimize virological response.

2. ___The patient is antiretroviral-naïve, and therapy is being initiated for chronic HIV infection present not more than 2 years. Resistance testing at baseline is recommended since some resistance-associated mutations are known to persist in the absence of drug pressure.

3. ___The patient is antiretroviral-naïve, and there is a significant probability that he/she was infected with antiretroviral-resistant virus due to a specific history of apparent unprotected sexual exposure to an antiretroviral-experienced partner.

4. ___Antiretroviral therapy (ART) is being initiated in a new patient, not previously known, who is not currently receiving antiretroviral therapy, but who gives a history of past antiretroviral exposure from another caregiver or institution.

I understand HIV genotypic resistance testing may only be ordered under the following conditions:

1. The applicable criterion above has been fully documented in the patient's medical record;
2. ART therapy and adherence have been discussed with the patient as part of his/her medical treatment;
3. The patient has acknowledged an understanding of treatment goals and expressed his/her intent to adhere to ART therapy;
4. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml.

Test ordered: ____Genotype ____Genotype with Data Base Match (Virtual Phenotype)

Sincerely,

_____, M.D.

_____ _____
Print Physician's name Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiañp, Program Director, Office of Strategic Business Management, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (G) of the Ryan White Title I Professional Service Agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

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RYAN WHITE TITLE I PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL HIV GENOTYPE RESISTANCE ASSAYS: ANTIRETROVIRAL FAILURE

Date:_____

A MAXIMUM OF TWO (2) ANTIRETROVIRAL RESISTANCE TESTS MAY BE ORDERED IN ANY TWELVE (12) MONTH CONSECUTIVE PERIOD TO INCLUDE NO MORE THAN ONE (1) HIV PHENOTYPE IN ANY CONSECUTIVE TWELVE (12) MONTH PERIOD. IF THE PATIENT IS ELIGIBLE FOR HIV GENOTYPE TESTING UNDER ADAP, THE PATIENT IS NOT ELIGIBLE TO RECEIVE THIS TEST UNDER RYAN WHITE TITLE I.

As the primary medical caretaker for _____it is my considered opinion that he/she requires HIV genotypic resistance testing. The following criterion has been met:

1. ___The patient has sub-optimal suppression of the viral load following initiation of antiretroviral therapy (ART) as defined by the current medical guidelines of the Department of Health and Human Services;
   OR
2. ___The patient has experienced virologic failure during combination ART as defined by the current medical guidelines of the Department of Health and Human Services.

I understand HIV genotypic resistance testing for antiretroviral failure may only be ordered under the following conditions:

1. The applicable criterion above has been fully documented in the patient's medical record;
2. It appears the patient has been fully adherent to his/her current antiretroviral treatment regimen;
3. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment;
4. The patient's two most recent plasma HIV RNA (viral loads) must be at least 1000 copies/ml at the time of testing. At least one reading must be less than 3 months old;
5. The patient must be on antiretroviral medications at the time of testing or off medications no more than 2 weeks prior to testing.

Test Ordered: ___Genotype ___Genotype with Data Base Match (Virtual Phenotype)

Sincerely,

_____, M.D.

_____ _____
Print Physician's name Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

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Rev. 2/1/06

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RYAN WHITE TITLE I PROGRAM
LETTER OF MEDICAL NECESSITY FOR
ANTIRETROVIRAL PHENOTYPE RESISTANCE ASSAYS FOR EXPERIENCED PATIENTS
COVERAGE IS LIMITED TO A MAXIMUM OF ONE PHENOTYPE IN ANY CONSECUTIVE TWELVE MONTH PERIOD.

Date:_____

As the primary medical caretaker for _____it is my considered opinion that he/she requires HIV phenotypic resistance testing. The following criteria have been met:

1. The patient at any time in the past has failed two (2) or more antiretroviral (ARV) regimens;

2. Results of at least one, preferably more, prior genotype(s) must be available in the chart and Resistance to two or more drugs per class in at least two classes of ARVs is present on prior genotype(s);

AND ONE OF THE FOLLOWING (check-off the appropriate condition below):

___Prior genotype(s) show(s) resistance to at least 2 PIs other than ritonavir and use of a PI is being considered;

OR

___Lopinavir/ritonavir is being considered in a PI-experienced patient with four or more mutations associated with resistance to lopinavir/ritonavir on a prior genotype;

OR

___Four or more mutations at codons associated with PI cross-resistance are present;

OR

___M184V mutation is present in the presence of 3 or more NRTI-associated mutations (NAMs);

OR

___K65R mutation is present, or other mutations associated with NRTI cross-resistance (69 insertion complex or 151 complex);

OR

___ Rescue ARV regimens guided by results of two or more prior genotypes have failed to suppress viral replication, whether mutations present or not, and the patient has been determined to be adherent on re-evaluation. (Requires a minimum of two prior genotypes.)

I understand HIV phenotypic resistance testing for experienced patients may only be ordered under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record;
2. Adherence has been discussed with the patient on an on-going basis as part of his/her medical treatment, and it has been determined that the patient is fully adherent with his/her current ART regimen;
3. The patient's plasma HIV RNA (viral load) at the time of testing must be at least 1000 co/ml within the past month (attach copy to letter of medical necessity);
4. The patient must be on antiretroviral medications at the time of testing.

Sincerely,

_____, M.D.

_____ _____
Print Physician's name Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

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Rev. 2/1/06

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for
Appetite Stimulant

Date:_____

As the prescribing physician for _____, who has a diagnosis of _____, it is my opinion that an appetite stimulant is medically necessary for this patient (check the appropriate box):

☐ Dronabinol (Marinol) –maximum of 2.5mg b.i.d. dosage*

☐ Megestrol (Megace)

[***NOTE:** Title I funds may only be used to cover a maximum of 2.5 mg b.i.d. dosage of Dronabinol (Marinol).]

The patient's prognosis is _____.

The physician prescribing this medication **MUST** sign and date the Letter of Medical Necessity for Appetite Stimulant attesting to the following:

1. This appetite stimulant will play a vital role in maintaining the patient's degree of wellness by preventing malnutrition, pancreatic and/or digestive insufficiency. This patient has failed to gain or maintain weight with a standard dietary intake. Without this medication this patient will have to be hospitalized.

2. I have tried other dietary regimens such as high calorie high protein meals, pureed food, fortified milkshakes, etc., with my patient with no results. I believe that the appetite stimulant _____ is medically indicated in this case.

3. I understand the need for this appetite stimulant to be reassessed every three (3) months (original prescription and two (2) refills) and for a Letter of Medical Necessity for Appetite Stimulant to be completed every three months for a maximum of two (2) refills per prescription.

Sincerely,

Patient's Height _____

_____, M.D.
SIGNATURE

Patient's Weight _____

_____
PRINT NAME
(Physician)

_____
Florida Medical License # (MEO#)

_____
Patient's 10 digit Medicaid # (if applicable)

_____
Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

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RYAN WHITE NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in ADULTS

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

_____
PRINT NAME
(Registered Dietitian/Nutritionist)

_____ _____
SIGNATURE Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Nutrition Products Available Through Ryan White Title I

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ ☐ Lbs ☐ Kgs IBW/UBW: _____ ☐ Lbs ☐ Kgs

NOTE: *1 Serving = 2 Scoops*

☐ Progain Powder - ___ No. of **SERVINGS per DAY** ☐ Vanilla ☐ Chocolate
(HIGH calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/dietitian as indicated above)

☐ IgG Pure - ___ No. of **SERVINGS per DAY** (Only natural flavor available)
(LOW calorie product)
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above)

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.
Patient's 10 digit MEDICAID Number: _____

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RYAN WHITE NUTRITIONAL SUPPLEMENTS
Letter of Medical Necessity for Supplementation in CHILDREN

Date: _____

As the primary medical caretaker for _____, who has a diagnosis of HIV/AIDS, it is my considered opinion that he/she requires enteric nutritional supplements.

I believe that nutritional supplements are medically indicated in this case and I have referred this patient for a professional Nutritional Assessment by a Registered Dietitian/Nutritionist.

I understand enteral nutrition must be evaluated by a Dietitian/Nutritionist every _____. *(Please indicate period of time for nutritional re-evaluation. Number of refills authorized cannot exceed this period of time.)*

Sincerely,

_____, M. D./ D.O./ ARNP/ PA-C
SIGNATURE
(Physician, Nurse Practitioner or Physician Assistant)

_____ _____
PRINT NAME Florida Medical License #
(Physician, Nurse Practitioner or Physician Assistant)

_____
PRINT NAME
(Registered Dietitian/Nutritionist)

_____ _____
SIGNATURE Dietitian/Nutritionist Florida License #
(Registered Dietitian/Nutritionist)

Nutrition Products Available Through Ryan White Title I

Physician/ Nurse Practitioner/ Physician Assistant/ Dietitian/ Nutritionist, please indicate preferred product, flavor, number of servings recommended and number of refills authorized. *(Dietitian/Nutritionist, please refer to the Criteria for Dispensing Nutritional Supplements FORM for patient's nutritional assessment on back page.)*

Please document patient's: Height: _____ Weight: _____ ☐ Lbs ☐ Kgs IBW/UBW: _____ ☐ Lbs ☐ Kgs

NOTE: *1 Serving = 1 Can (8 fluid ounces)*

Boost Liquid is restricted to Children 18 years and under

Boost Liquid- _____ No. of **SERVINGS per DAY**
Number of Refills Authorized _____
(Number of refills authorized cannot exceed period of time for re-evaluation by nutritionist/ dietitian as indicated above.)

Please indicate FLAVOR preference: ☐ Vanilla ☐ Chocolate ☐ Strawberry

Resource Just for Kids is restricted to Children 1 - 10 years of age

Resource Just for Kids- _____ No. of **SERVINGS per DAY**
Number of Refills Authorized _____

Please note: If the patient is on MEDICAID, please refer to the MEDICAID Medical Necessity Request Letter.
Patient's 10 digit MEDICAID Number: _____

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RYAN WHITE

CRITERIA FOR DISPENSING NUTRITIONAL SUPPLEMENTS

The following are potential situations where commercial nutritional supplements could be considered medically indicated.

Patient must meet at least two (2) criteria listed below.
(Consultation with a Registered Dietitian/Nutritionist for nutritional assessment and a Letter of Medical Necessity are required.)

Please check all that apply:

___ Current body weight < 10% IBW/UBW
___ Weight loss of:
- 5% of the initial/baseline weight over the past month -OR-
- 7.5% over the past 3 months -OR-
- 10% weight loss within the last 6 months

___ Body Cell Mass (BCM) < 40% (MALES) or BCM < 35% (FEMALE) of IBW
___ Body Mass Index (BMI) < 20
___ Recent illness/hospitalization that will interfere with patient's ability to consume or tolerate adequate non-supplemental nutrition
___ Diarrhea/malabsorption with > 3 large, liquid stools/day
___ Dysphagia and/or odonyphagia where commercial supplements are the only source of nutrition tolerated
___ Serum albumin < 3.5 g/dl
___ Failure to gain/maintain weight in the past when following a dietary regimen to promote weight gain
___ Inadequate living conditions or inability to buy/prepare meals
___ Inability to understand and or follow nutritional recommendations

NUTRITIONAL PLAN FOR SUPPLEMENTS

I. INITIAL Consultation: Date: _____ Weight: _____

Patient assessed/instructed by Registered Dietitian/Nutritionist: **(Please check the appropriate box)**

☐ Nutritional supplements **recommended** ☐ Nutritional supplements **NOT** recommended

II. FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

III. ADDT'L FOLLOW-UP Visit: Date: _____ Weight: _____

Patient re-assessed for progress: **(Please check the appropriate box)**

☐ Nutritional supplements **continued** ☐ Nutritional supplements **discontinued**

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Olanzapine (Zyprexa)

SECTION I: **This section is to be completed by a prescribing healthcare provider for *INITIAL* Olanzapine (ZYPREXA) prescriptions NOT EXCEEDING 20mg PER DAY.**

Date: _____

As the PRESCRIBING HEALTHCARE PROVIDER for _____, who has a diagnosis of _____, it is my opinion that Olanzapine (Zyprexa) is medically necessary for this patient at a dose of _____.

I understand that a letter of medical necessity is required only for the **initial** prescription for Olanzapine (Zyprexa) **NOT** exceeding 20mg per day.

SECTION II: **This section is to be completed by a prescribing healthcare provider for *ALL* Olanzapine (ZYPREXA) prescriptions *EXCEEDING 20mg PER DAY***

Date: _____

As the PRESCRIBING HEALTHCARE PROVIDER for _____, who has a diagnosis of _____, it is my opinion that an Olanzapine (Zyprexa) dosage **exceeding** 20mg per day is medically necessary for this patient.

In addition, I am providing the following information as required by Ryan White Title I:

- Reason for Olanzapine (Zyprexa) dose > 20mg/day _____
- **Previous** Olanzapine (Zyprexa) dosage _____
- Duration of **previous** Olanzapine (Zyprexa) treatment _____

I understand that a letter of medical necessity is required for every new prescription of Olanzapine (Zyprexa) exceeding 20mg per day.

_____ Signature

_____ Print Name

_____ Florida medical license # (MEO#)

_____ Patient's 10 digit Medicaid # (if applicable)

_____ Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Pantoprazole
(Must be completed by a Gastroenterologist)

Date:_____

I, a Board-Certified gastroenterologist, hereby certify that _____, is a patient under my care who requires Protonix 40 mg for the treatment of Erosive Esophagitis, or Barrett's Esoghaus, or a hypersecretory condition. I certify that a proton pump inhibitor is medically necessary.

Sincerely,

_____, M.D. (DO)

_____	_____
Print Physician's name	Florida Medical License # (MEO#)
_____	_____
Patient's 10 digit Medicaid # (if applicable)	Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

This letter **must** be completed each time a new Protonix prescription is written to treat any of the conditions indicated above. It is not required for refills.

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Sporanox

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that he/she requires a prescription to take Sporanox in capsule formulation. The patient's prognosis is _____. The following criteria have been met:

1. The medication will be utilized to treat one of the following two conditions (please check one box):

☐	Histoplasmosis
☐	Aspergillosis

I understand Sporanox may only be prescribed under the following conditions:

1. The above criteria have been met and are fully documented in the patient's medical record
2. The patient has been diagnosed with either histoplasmosis or aspergillosis.

Sincerely,

_____, M.D.

_____ _____
Print M.D.'s name Florida medical license # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

Please note: All questions should be addressed to Ms. Theresa Fiaño, Program Director, Office of Strategic Business Management, at (305) 375-4742. Requests for information/clarification of a clinical nature will be forwarded by Miami-Dade County to the Miami-Dade HIV/AIDS Partnership Medical Care Subcommittee and/or a qualified member of the Subcommittee.

Pursuant to Article VI, Section 6.4 (G) of the Ryan White Title I service agreement, Miami-Dade County has the right to access all client files (including electronic files), service utilization data, and medical records during on site verification or audit by County personnel and/or authorized individuals to confirm the accuracy of all information reported by the service provider.

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity to Accompany Initial Prescription for
Testosterone Gel (Androgel® 1%, Testim® 1%)
(MUST ACCOMPANY INITIAL REFERRAL TO THE PHARMACY ALONG WITH A PRESCRIPTION)

Date: _____

As the prescribing physician for _____, who has a diagnosis of low serum testosterone level*, it is my opinion that testosterone replacement with testosterone gel (Androgel® 1%, Testim® 1%) is medically necessary for this patient. The following criteria have been met and required information submitted.

The medication will be utilized to treat low serum testosterone level* **if** the following are met:

1. The patient has a documented history of prior intramuscular (IM) long acting testosterone use for _____ (amount of time).

2. There is an existing contraindication to the injectable formulation whereby the patient has a history of a medical condition in which the use of the different intramuscular injection sites is contraindicated (i.e., infection/abscess at all injection sites). **Please specify the reason for the contraindication** (check the appropriate box):

   ☐ Hemophilia
   ☐ Anticoagulation – patient is on Coumadin
   ☐ Infection/small abscess at injection site until infection resolves
   ☐ Thrombocytopenia

   Please provide the following ***PATIENT INFORMATION***:

DATE parameter measured:	**PARAMETERS**			
	Height:			
	Weight:	Lbs	or	Kg
	Serum Testosterone Level:			

* A testosterone level below normal as measured by the reference lab. Please submit with the **initial** referral and prescription a copy of the dated lab report with testosterone level results.

Sincerely,

_____, M.D.
SIGNATURE

_____ _____
PRINT NAME (Physician) Florida Medical License # (MEO#)

_____ _____
Patient's 10 digit Medicaid # (if applicable) Patient's CIS # (assigned by the Ryan White Title I Service Delivery Information System)

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RYAN WHITE TITLE I PROGRAM
Letter of Medical Necessity for Valacyclovir (NEW PRESCRIPTIONS)

Date:_____

As the primary medical caretaker for _____, who has a diagnosis of _____, it is my considered opinion that (check **one** of the following)

☐ Valacyclovir 500mg

☐ Valacyclovir 1000mg

is medically necessary for this patient. The following criteria has been identified and documented in the patient's chart (the physician must initial next to the box corresponding to the medical condition that applies to this patient):

☐ This Patient requires Valacyclovir daily suppressive therapy (usual dose is 500mg twice daily) for recurrent Herpes Simplex episodes occurring while receiving standard doses of daily suppressive Acyclovir therapy (usual doses are between 400mg and 800mg twice to three times daily).

☐ This patient has acute Herpes Zoster, and requires Valacyclovir 1000mg three (3) times daily. A ten (10)-day supply, refillable once only, may be provided per episode.

OR

Note: To qualify for daily suppressive Valacyclovir therapy, a patient must have had more than one Herpes recurrence while receiving daily Acyclovir suppressive therapy. This must be documented by attaching a photocopy of a recent Acyclovir prescription to this Letter of Medical Necessity when submitted with the first prescription for Valacyclovir tablets. This is not a requirement for subsequent refills.

I understand Valacyclovir may only be prescribed when one of the criteria specified above has been met and is fully documented in the patient's medical record.

Sincerely,

_____, M.D.

_____ _____
Print M.D.'s Name Florida Medical License # (MEO#)

_____ _____
Patient's 10 Digit Medicaid # (if applicable) Patient's CIS #
(ID number assigned by the Ryan White Title I Service Delivery Information System)

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RYAN WHITE TITLE I PROGRAM
Prior Authorization Form for Neupogen® (Filgrastim)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____
Prescriber Full Name:_____ Prescriber License #: (ME,OS,RN)_____
Prescriber Telephone #:_____ Prescriber Fax #:_____
Drug Strength: _____

Please check below the diagnosis or indication for this product:

□ Severe neutropenia in AIDS patients on antiretroviral therapy
Severe Chronic Neutropenia: □ congenital □ cyclic □ idiopathic
□ Cancer patients with HIV/AIDS receiving myelosuppressive chemotherapy

Select one of the following:

New Therapy □ **OR** Continuation of Therapy □

Lab Test Date: _____ Absolute Neutrophil Count: _____ cells/mm3

What is the date range of therapy? Begin Date: _____ End Date: _____

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Hand Deliver, Mail or Fax information to:

Mercy Professional Pharmacy
3661 South Miami Avenue, Suite 110
Miami, FL 33133
Telephone #: (305) 285-2762 (for information only)
Fax #: (305) 285-5019 **OR** (305) 285-2606

OR

AIDS Healthcare Foundation
375 N.E. 54th Street, Suite 3
Miami, FL 33137
Telephone #: (305) 758-1984 (for information only)
Fax #: (305) 758-8714

FOR RYAN WHITE TITLE I USE ONLY

Date: _____ **Notified:** _____

Approved: _____ **Start Date:** _____ **Expiration Date:** _____

Denied: _____ **Reason:** _____

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RYAN WHITE TITLE I PROGRAM
Prior Authorization Form for Procrit® (Epoetin)

Recipient's Full Name:_____ Date of Birth: _____ /_____ /_____
Prescriber Full Name:_____ Prescriber License #: (ME,OS,RN)_____
Prescriber Telephone #:_____ Prescriber Fax #:_____
Drug Strength: _____

Please check below the diagnosis or indication for this product:

- □ Anemia associated with HIV
- □ Anemia associated with renal failure if patient is not on dialysis
- □ Anemia associated with chemotherapy
- □ Other _____

Select one of the following:

New Therapy □ **OR** Continuation of Therapy □

Does the patient have active gastrointestinal bleeding? □ YES **OR** □ NO

Lab Test Date:_____ Hematocrit:_____% Hemoglobin:_____g/dl

Indicate dosage and frequency of dosing: _____

Prescriber's Signature: _____

Please attach a copy of the original prescription and lab results dated within the last two (2) months.

Hand Deliver, Mail or Fax information to:

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3661 South Miami Avenue, Suite 110
Miami, FL 33133
Telephone #: (305) 285-2762 (for information only)
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FOR RYAN WHITE TITLE I USE ONLY

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